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AUTHOR Newberger, Eli H.; Hyde, James N., Jr.
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ABSTRACT

This paper summarizes data and experience with child abuse pertinent to child health practice. It goal is to foster sound and rational medical management. Because of the complex origins of child abuse, however, and of the institutional and social changes which shall have to accompany excellent practice if child abuse is effectively to be treated and prevented, issues of program and policy development are also addressed. The knowledge base about child abuse is conceptually and methodically limited. Our understanding of the problem of child abuse is broadened by several recent descriptive reports which demonstrate that childhood accidents and child abuse are temporally associated, that the parents of abused children are rarely neurotic or psychotic, and that the developmental sequelae of child abuse and neglect are serious. Child abuse has also been observed to be associated with poverty, low birth weight, parental alcohol and drug abuse, crime, social isolation, marital stress, and unemployment. The coordinated, interdisciplinary management of child abuse may reduce the toll of reinjury while children stay in their own homes. A helpful integrating concept in the diagnosis and treatment of child abuse is the family's capacity to protect its child, either from the consequences of their own angry feelings toward him, or from the hazards of his nuturing environment. (Author/JM)

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CHILD ABUSE: PRINCIPLES AND IMPLICATIONS OF CURRENT PEDIATRIC PRACTICE

Eli H. Newberger, M.D.* and
James N. Hyde, Jr., M.S.**

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Introduction:

This paper summarizes data and experience with child abuse pertinent to child health practice. Its goal is to foster sound and rational medical management. Because of the complex origins of child abuse, however, and of the institutional and social changes which shall have to accompany excellent practice if child abuse is effectively to be treated and prevented, issues of program and policy development are also addressed.

What is Child Abuse?

The classic paper of Kempe and colleagues defined "the battered child syndrome" as "a term used by us to characterize a clinical condition in young children who have received serious physical abuse, generally from a parent or foster parent." [26] For the medical professional especially, which previously had not recognized a phenomenon centuries old, the impact of the paper was considerable. [41] The concept of child abuse as inflicted injury in the Kempe paper was admittedly narrow and was associated with constricted definitions of child abuse in the state child abuse reporting statutes which proliferated after the paper's publication.

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*Eli H. Newberger, M.D., Director, Family Development Study, Children's Hospital Medical Center, Boston, Mass. Instructor in Pediatrics, Harvard Medical School.

**James N. Hyde, Jr., M.S., Administrator, Family Development Study, Children's Hospital Medical Center, Boston, Mass. Research Associate in Pediatrics, Harvard Medical School.

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Fontana proposed a more broadly defined "maltreatment syndrome," where the child "often presents itself without obvious signs of being battered but with the multiple minor evidences of emotional and, at times, nutritional deprivation, neglect and abuse. The battered child is only the last phase of the spectrum of the maltreatment syndrome."[9]

Underlying both narrow and broadened definitions of child abuse are implicit concepts of parental fault, which are vividly underlined in Fontana's introduction to his book "The Maltreated Child:" "This malicious abuse and neglect of children is a medical-social problem of major proportion. It is plaguing our society by killing and crippling untold numbers of defenseless children....Today...the important battle continues between the child murderer and the child saver."[9]

Such strong and angry responses to child abuse are not rare in the professional literature and in journalistic treatments of the subject. They derive in part from the intense feelings which cases of child abuse evoke in everyone and in part from our limited understanding of a complicated problem with multiple causes and many manifestations in child, adult personality, family, environment and culture.

The knowledge base about child abuse remains conceptually and methodically limited, as the following statement in a working paper for the Joint Commission on the Mental Health of Children pungently points out: "We can state without equivocation that in view of the ubiquity of the problems here under view, and their contribution to a myriad of other social ills, the paucity of studies of substance and rigor is shocking...Endless fritterings of academic nonsense have gained funding under the dubious claim of constituting basic research, as if theoretical advances had never arisen from applied fields. Most such studies are of

children easily brought under study, which usually implies considerable interest and intactness in their parents' personalities."[39]

Our understanding of the problem of child abuse is broadened by several recent descriptive reports which demonstrate that childhood accidents and child abuse are temporally associated,[11,19,23] that the parents of abused children are rarely neurotic or psychotic,[31] and that the developmental sequelae of child abuse and neglect are serious.[7, 30] Child abuse has also been observed to be associated with poverty, low birth weight, parental alcohol and drug abuse, crime, social isolation, marital stress, and unemployment.[14, 16, 27-29, 43, 44] There is also data which suggests that the coordinated, interdisciplinary management of child abuse can reduce the toll of reinjury while children stay in their own homes.[4, 35]

A helpful integrating concept in the diagnosis and treatment of child abuse is the family's capacity to protect its child, either from the consequences of their own angry feelings toward him, or from the hazards of his nurturing environment.

The great critic of life in London in the 18th century, William Hogarth, visually summarized the impact of alcoholism on the community in his Gin Lane.(Figure 1). Here are portrayed at least three visual metaphors of different aspects of a broadly conceived notion of child abuse: a mother's death and her child's abandonment, a child impaled on a stake, and, prominently in the foreground, a baby tumbling from its drunken mother's arms to the tavern sidewalk below.[22]

(Figure One About Here)

Were one to be in medical practice on Gin Lane in London in 1751 and to be armed with the insight of Kempe's 1962 paper, one might wonder whether the infant of an alcoholic mother brought in with a subdural hematoma was a victim of the "battered child syndrome". Yet what is more centrally at issue here, and what can be the focus of the diagnostic effort when such injuries, abandonments and neglectful circumstances present for care in the present day, is the extent to which a child's life context is protective and supportive. The injury of the baby tumbling from its mother's arms may be regarded as a symptom, in this example both of maternal alcoholism and of the social and cultural conditions associated with a high prevalence of alcoholism in the community. Whether or not the injury was intentionally inflicted is of interest and possibly of importance, but understanding its origin and identifying what can be done to strengthen the child's environment might better be the goals of diagnosis of child abuse.[34]

This is not to say that a parent's anger, expressed violently or passively toward a child, is not primary in many child abuse cases. The work of Steele and others, has drawn attention to abusing parents' excessive and premature expectations of their children.[12, 45] Often, the angry feelings of which the child's injury is a symptomatic expression appear to derive from the violent circumstances or deprivation of the parent's own upbringing, and they may reflect a deep disappointment that the child has not been able adequately to fulfil the parents' own nurturing needs.[24, 27] This last phenomenon has been called "role reversal" in the psychiatric literature.[32] It is indeed important in one's conversations with parents to ask about their feelings toward the child and to find out about what their own childhoods were like. A particularly sensitive

chapter on how to approach parents of an abused child is found in "Helping the Battered Child and His Family."[40]

The great cartoonist Rube Goldberg[17] (Figure 2) documented with characteristic flourish what might be interpreted as one parent's ability to protect his baby who awakened him in the middle of the night and made him angry. The contraption which protects the baby from father's discomfort and subsequent anger is elegantly described:

> "Pull string(a) which discharges pistol (b) and bullet (c) hits switch on electric stove (d), warming pot of milk (e). Vapor from milk melts candle (f) which drips on handle of pot causing it to upset and spill milk down through (g) and into can (h). Weight bears down on levers (i) pulling string (j) which brings nursing nipple (k) within baby's reach.
>
> In the meantime baby's yelling has awakened two pet crows (l & m) and they discover rubber worm (n) which they proceed to eat. Unable to masticate it, they pull it back and forth causing cradle to rock and put baby to sleep.
>
> Put cotton in your ears so you will not be bothered if baby wakes again-----."

(Figure Two About Here)

In the development of a program to help a family better to protect its offspring, one must be concerned not to construct too elaborate a contraption, nor, as the cartoon might lead one to think, simply to safely distance child from parent. One needs to identify <u>strengths</u> in a family which can be built upon and <u>resources</u> which can operate effectively to integrate safely child and parent.

Case Examples: Application of the Protective Concept in Diagnosis and Initial Intervention

Case One (Figure 3): Drugs, Injury and Denial

A ten month old male infant was brought to the Emergency Room by his mother, a nineteen year old unkempt woman who on arrival said that she had recently been taking illegal psychoactive drugs. Physical examination showed a stuporous child with a massive hematoma overlying the left orbit. On inspection the right eye was deviated leftward. The mother volunteered that she had been in the child's room where quite by chance a broom had fallen over a shoe. She inadvertently stepped on the shorter side of the broomstick, which, with the shoe as a fulcrum, catapaulted the broom into the child's crib, hitting him on the head and causing his injury.

(Figure Three About Here)

Comment

This blatantly fabricated explanation for the child's injury might be taken by a physician or nurse, angered by such a grievously injured baby, as an intentional falsification. One might be tempted to hammer away at the proferred story in an effort to make a definitive diagnosis of the "battered child syndrome." This might expiate some of one's own angry feelings, but it might actually harm the prospects for the establishment of professional relationships in order that both mother and child can receive the treatment they desperately need.

The mother's story should be accepted for the moment, and it should be construed by the professionals managing the case as representation of how profoundly threatening to the mother's sense of herself is the reality

that she has been so unable to protect her baby. Her denial of this reality may be seen as a desperate attempt to hold herself together and there may be a conscious effort to conceal the facts of the injury for fear of legal, punitive reprisal. Shorn of her defenses by an interrogatory diagnostic approach, she might resort to a more primitive ego defense, such as resistance to talking about the problem at all, blaming the hospital for the injury, or taking the child and running from the hospital.

One needs to give the child the emergency treatment and protection it requires and to attend to the parent's distress at the same time. It is appropriate to emphasize to the parent the need for the child's treatment and protection and to express one's ability and interest in helping the parent through this crisis, too. This is a difficult and vexing process for doctors and nurses, who are often overcome with anger toward abusing or neglectful parents. It is well to keep in mind the need to form a helping relationship which will lay the groundwork for future intervention to strengthen the protective ability of the mother and her tie to her child. This long-term management goal can be identified and kept in mind from the outset, notwithstanding the implicit or explicit efforts of the parent to obscure the true instrument, timing, and circumstance of the child's injury, the parents' social status or personal attractiveness, and one's own angry feelings toward the parent.

Case Two (Figure 4) Poverty, Depression and Severe Neglect

An eight month old child came to the Emergency Room with her mother who complained of her inability to gain weight. The mother was poorly dressed and obviously depressed. Physical examination showed a tiny, emaciated child who did not respond to play. There were moderate hip and elbow contractures. The weight and length were well below the third

percentile of the normal distributions of these parameters.

The patient's mother was unmarried, and this was the fourth child of a fourth father. She was born and raised in North Carolina, where she left her oldest child on coming to Boston a year before to find work as a domestic. Both maternal grandparents were seriously ill in North Carolina. She had no child care for her two older preschool children. Mother and children were supported by Aid to Families with Dependent Children; the stipend was about $235.00 a month, of which $115.00 went for rent. The mother said her teeth ached constantly, but she had been unable to get to a dentist. She also complained of back pain, fever and listlessness, and a urinary tract infection was shortly discovered.

(Figure Four About Here)

Comment

Were one so inclined, one could, on the basis of medical criteria alone, argue successfully in virtually any district, juvenile or family court in the United States that this child was in need of care and protection and should be found by the Court to be dependent on the State. Such a practice, which occurs regularly, could aptly be characterized as a form of "blaming the victim".[42] Here, both mother and child can be seen as victims of a social system which distributes jobs, goods, and child health and child development resources unequally.[15]

In this case, a young, depressed mother failed abjectly in her wish to settle her family in an alien metropolis. She dould not get child care, dental care, decent employment, or health care, including contraceptive services. Her child's neglect was not taken to be her

fault, and a compassionately conducted family assessment permitted identifying a management program which enabled the child to thrive in her care. On discharge from the hospital, a homemaker came three days a week, a visiting nurse on alternate days. Weekly clinic visits were scheduled. Preschool services were found for her two older children. A social worker gave weekly counseling, which was associated with a fine increase in the mother's self esteem. Dental and medical treatment, along with the other elements in the management plan, were coordinated by the social worker.

At a five year follow-up interval, the patient was physically and psychologically normal (Figure 5). Her family, including a new younger brother, were happy and healthy (Figure 6).

(Figures 5 and 6 About Here)

It is frequently easier in such cases to go to court and to remove the child from its mother's care. Homemaker, child care, counseling, and dental services, to this day, remain expensive and difficult to obtain. The long-term effects for child and family of foster home placement, however, are known from recent studies both to be psychologically and financially costly.[8, 20] It is essential that medical personnel invest the necessary time and energy to assure that when possible families can stay together. To do so may involve, as it did in this case, time consuming conferences with the Welfare Department, letters requesting homemaker and

nursing services, purposeful and systematic efforts to engender a relationship of confidence and trust with a parent with no previous successful experience with helping services, and convincing one's skeptical colleagues that staying with its family may be in the child's best long-term interest.

The arguments advanced in the recent book "Beyond the Best Interests of the Child" have been influential in framing discussions of the management of individual cases. In this book, distinguished figures in psychiatry and law propose that the traditional criterion for decision-making in child welfare cases ("the best interest of the child") is insufficient. One would often do better, they note, to chose "the least detrimental alternative". Such a concept provides a yardstick to measure for the child in question the impact on his development of a decision affecting his family.

At the time the critical judgement was made to invest professional resources in this fragile family, one could not have been sure that the decision to send the child home with her mother was "the least detrimental alternative." Now it appears to have been. The capacity to predict the differential outcome of various interventions is limited. This is a provocative and helpful book for medical personnel concerned with child abuse and neglect, although a superficial reading of it may arm one's colleagues (if not oneself) with apparently simple and unitary formulas for complicated clinical problems with multiple causes. These demand flexibility and creativity in deploying intervention tools appropriate to each case.

Case Three (Figure 7) New Year's Eve and a "Battering Sibling"

A two and a half year old girl was brought by the police to the Emergency Room in a blanket after having been found unconscious on the

grass outside a housing project on New Year's Eve. The outdoor temperature was in the low thirties. Physical examination showed a semicomatose child whose skin revealed a 3 cm. linear laceration of the left buttock and poor general physical hygiene, including tatoos of dirt on the plantar surfaces of both feet.

The child's mother arrived at the hospital within the hour and informed the physician that she had left the patient in the care of her five year old sibling. According to the sibling, the two had been running naked in the apartment, when the older child, angered at the patient, took a knife and chased her, managing to lacerate her buttock before she climbed upon the window ledge, and in her desperation to escape from her sister, opened the window and jumped from the sixth floor.

Further interview disclosed that the patient's mother became pregnant with the older sibling, whose behavior had previously been noted by a local health center to be distressed, when she was a resident at a training school for girls, to which she was sent by the juvenile court after her mother asked her to be declared a stubborn child. By virtue of the child's birth, she became an emancipated minor. She was liberated to live with her child in a housing project on an Aid to Families with Dependent Children stipend, estranged from her mother and family and alienated from the social "services" which had so clumisly intervened in her own young life.

(Figure Seven About Here)

Comment

One might look on this case as an example of the "battering child" syndrome[35] and simply attribute the child's abuse to a different "perpetrator" than the parent customarily identified as the cause of the child's injury. Similarly, a more penetrating and accurate formulation might address the obvious failure of the mother to protect her two year old from her predatory sister. Both "diagnoses" are correct, in the sense that they address proximal causes of the presenting lesions. Unfortunately, however, the roots of the problem extend deeper. One may look on this patient's injuries as symptoms of more complex familial and social problems, which challenge one's capacity as a medical worker to cure the individual case or to prevent future similar cases.

The origins of the two-year old's injury derive at least two generations back, from the distressed relationship between her mother and grandmother. The court action which led to the mother's placement in a training school -- in reality a prison for children -- may have been the only way that the grandmother was able to get help for her problems with her teenaged daughter. This is an example of how so often, as Bronfenbrenner aptly noted, American service institutions are divisive rather than integrative of families.[36] Additionally, one might observe that the services which society made available to this young mother when she was a child, the Court and the delinquency "program", could neither anticipate her future nor provide adequate services when she became a mother. Other social institutions, the Welfare "service" system, the Boston public housing "program," and the child health services which were equipped only to do minimal health promotion, conspired passively to let her not inconsiderable personal and psychological problems take their toll on her offspring.

It was only when her child was abused that a systematic and coordinated effort to provide counseling, child care, health care, homemaker, and better housing began. Ironically, and tragically, it was necessary to invoke the authority of the same Juvenile Court which committed her as an adolescent to force her to accept these services. It was impossible to convince this mother that we meant to help her better to care for her children. Her experience with "helping" services had been unrewarding or punitive, and she had no basis for trust.

As medical practice is currently organized, it is often impossible to operate effectively on the causes of individual child abuse cases such as this one. To prevent future such cases will require attention to the distribution and quality of such social services as housing, health and counseling, the courts, schools, as well as opportunities to compete for the essential goods of society.

The disturbing question of whether our culture actually <u>needs</u> child abuse has been raised by Gil and by Gelles.[16, 13] Simply summarized, the question is whether the sensational nature of the problem conveniently obscures its true social determinants (Gil uses the provocative metaphor "smokescreen" of public and professional interest), both because of society's need to obscure its neglect of so many of its young by depriving them of the resources necessary for them to grow in families whose basic needs for goods and services are met, and because of individual families' needs to make acceptable their own violent parenting practices.

The acceptance if violence in the culture is undoubtedly part of the complex causal underpinning of child abuse. A vivid visual reminder of the acceptability, and even the desirability, of violence in our culture is found on Figure 8, which portrays the culmination of a "Fox Kill" in rural Virginia. Here, a toddler is giving the <u>coup de grace</u> to a fox

driven from its lair into a circle of waiting clubs.

(Figure Eight About Here)

These three cases give a general impression of the complexity of child abuse. Its diagnosis requires more than a comfortable reconciling of symptoms with parental explanation; its management includes tools not found in the medical clinician's own office; and its prevention shall involve addressing cultural traditions, social values, and economic realities which exert a deleterious impact on a family's ability to protect its offspring.

The next case raises another complex set of questions, including the mental illness of a parent and the problems associated with the reporting of middle-class families where child abuse has occurred.

Case Four (Figure Nine) A Professional Person's Child

A three week old male infant was brought to the Emergency Room by his mother, who promptly informed the staff that the child had received his injury, a hand-shaped ecchymosis over the left temperoparietal area, at the hands of his father, a professional person who worked in another hospital in the Boston area. The professional staff was reluctant to report the case, as mandated by law, to the Department of Public Welfare. The father was seen by a social worker and psychiatrist, who noted a severe personality disorder, with paranoid features and poor impulse control. He associated the birth of his first child with a sense of abandonment by his wife.

(Figure Nine About Here)

Comment

In the present case, the issue of primary adult psychopathology is raised. The findings in the psychiatric and psychological literature are somewhat in conflict on this point. One controlled study of the personalities of abusing parents indicates no definite pattern of neurosis, drawing attention to severely frustrated dependency needs and serious parental inabilities to empathize with their children.[31] Another larger study, where the cases were of significantly lower social class than the controls, indicated a high prevalence of parental personality disorders and neuroses.[44] Here, the psychiatric consultant's perceptions and recommendations were helpful in treating the problem.

It is well known that professional personnel are frequently reluctant to report child abuse cases from middle and upper-class homes. Surveys of the private practitioners who care for the children of more affluent families indicate that they are seeing many more cases than they report.[2, 36] And the 1965 poll of a representative sample of ordinary American citizens conducted by the National Opinion Research Center as part of Gil's national study of child abuse in the late 1960's led to a national incidence extrapolation for which the 95% confidence interval was 2.5 to 4.03 million cases, at a time when fewer than 7,000 cases were reported each year.[16] The data suggest that child abuse is more prevalent among middle and upper-class families than case reports indicate.

The same survey also posed the intriguing question...."Could

you injure a child under a year of age in your care?" to which 6 of 10 respondents gave an affirmative reply.

A disproportionate number of families who are poor and/or non-white appear in case series of child abuse and in registers of child abuse case reports. To what extent do the circumstances of poverty contribute to this apparently greater frequency of the phenomenon among poor people? And to what extent does the preferential selection for reporting of impoverished families make it appear that poor people abuse their children more? Recent research findings suggest that certain environmental and social stresses are importantly associated with child abuse.[37] These may be experienced disporportionately -- but not exclusively -- among the poor.

Figure 10 displays child abuse case reports to the Boston area Welfare Department in 1971.

(Figure Ten About Here)

The legend at the top which summarizes the numbers of cases reported by physicians in practice suggests in part why such a large number of the cases on the polls were poor. The reports came predominantly from four inner-city hospitals with active emergency services, where poor families' children receive episodic primary pediatric care. Also of note in the figure is the high weekly prevalence of child abuse in the week before Christmas. This implies that child abuse, like such other human troubles as suicides, disturbances in prisons and mental hospitals, and violent crimes, gets worse at times of year when people long for missing family

supports, and, in their desperation, may turn on their children when they make unacceptable nurturing demands.

How Extensive is Child Abuse?

There have been many efforts in the interval since Kempe's landmark paper to gather insight into the extent of the problem of child abuse in America. Gil's projected upper-bound estimate of between 2.5 and 4 million cases each year[16] contrasts sharply with the extrapolation to the national experience of the findings of a 1970 survey of physicians and hospitals in Massachusetts.[33] The incidence figure which when applied to the population of all 50 states resulted in an annual estimate of 200,000 cases. In 1972, approximately 22,000 cases of child abuse were officially reported, while Kempe in the same year estimated that there were about 60,000 incidents.[6, 21]

One cannot but be impressed that information from such respected and competent sources can be so widely divergent. There are several explanations:

1. There is no uniform definition for the events being counted. While some experts employ narrow definitions, such as the one implicit in the "battered child syndrome", others include in their estimates children who are neglected or have suffered emotional abuse.
2. Estimates which derive from cases reported to state and local authorities reflect artifacts of bias in the reporting process itself of certain demographic groups which seem preferentially susceptible to being reported in different areas.

3. Incidence estimates derived from child abuse case reports lump together data from many different jurisdictions. These have criteria for reportability which are often quite divergent.

Clinicians may wonder why they should be concerned with the problems of defining the extent of child abuse. The matter is of concern because of the current state of the service delivery system and the availability of services for families whose children have been or are at risk of being abused. The recent enactment of federal child abuse legislation, PL-93-247, as well as the continuing evolution of state statutes across the country, has focussed national attention on the problem. At present there are few if any states which have child protective service personnel and resources available adequately to deal with the ever-increasing number of new cases reported, not to mention the much larger number of families who have already been identified as needing services. Because the services provided in the public sector are an integral part of the child abuse management system in all states, it is well for physicians and other professionals concerned with child abuse to be aware of disparities between need and service. Accurate data on the incidence of new cases and the prevalence of children already identified, and therefore still at risk, will be an important stimulus for the improvement of services to abused children and their families.

Overview of Current Child Abuse Reporting Legislation

Currently, all fifty States have child abuse reporting laws which mandate certain professionals to report cases of child abuse and/or neglect either to the State Department of Public Welfare or to another mandated agency for evaluation and intervention. While the specific details of these statutes vary from State to State, the format of the

individual laws follow similar patterns.[5, 10, 38]

Currently, 36 States incorporate Statement of Purpose clauses in their child abuse reporting statutes.[46] The majority of these statements speak to:

a) The necessity of providing protection to the child.

b) The prevention of further abuse.

c) The provision of services to families.

d) The non-punitive intent of the law: to help the family rather than to identify and punish the perpetrator of the act.

There is variability in the manner in which states have chosen to define abuse, and the trend nationally has been in the direction of broadening the definition. While some laws enumerate reportable conditions in technical language, others may define abuse as generally as "...exploiting a child to such an extent that the child's health, morals, or emotional well-being is endangered".[46]

As the trend in defining child abuse has expanded the criteria for reportable conditions, so too has the list of mandated professionals required to report been lengthened. All States require physicians to report. Thirty-four states require reporting by nurses, twenty-five by social workers, twenty-four by teachers, and nine States by police officers.[10] Additionally, sixteen States require reporting by "another person who has reasonable cause to suspect" and all States permit reporting by any citizen.[10]

Immunity from liability for reporting cases of suspected abuse is a universal feature of these statutes.

Most child abuse laws abrogate privileged communication between patient, client and physician, social worker, or other mandated professional when such communications involve child abuse as defined by the individual statute.

States generally follow the same model in delineating the contents of reports:

a) Name and address of the child and his/her parents.

b) Nature and extent of the reportable condition (injuries).

c) Age of the child.

d) Evidence of past injuries.

e) Additional information which might be deemed pertinent.

Many child abuse reporting laws treat extensively the procedure to be followed by the agency receiving a report. Most often this involves:

a) Investigation of the situation leading to the report within a specified period of time.

b) Provision of services to the victims and his family.

c) Authorization empowering the mandated agency to remove a child from its home in a bona fide emergency, in six States without having to prove in court the degree of danger.[46]

Most States include provisions for the establishment of a Central Register as a repository for information of all reported cases of abuse and neglect. There is wide variability in the manner in which these registers have been established, and individual statutes address the following issues:

a) Contents of the Register: Whether it should contain both "founded" and "unfounded" reports.

b) Confidentiality of information: Who has access to the file.

c) Expungement: Whether case records should be deleted, after certain time intervals, when a child reaches age of majority, or if a report is found after investigation to have been inaccurate or unwarranted.

The majority of states have provisions for some form of penalty for failure to report. The sanctions in these states range from a simple misdemeanor to one year in prison and/or a one hundred dollar fine. Kempe and Frazier have recently noted that a person failing to report a case of child abuse may be liable for damages in a civil suit.[25] They site two recent cases, in which physicians and a hospital were sued for malpractice. In one, a substantial award was made.

A more complete synopsis of individual state child abuse reporting statutes is found in "Child Abuse Legislation in the 1970's."[5] Table I is a compressed summary of aspects of the reporting laws of interest to medical practitioners.

(Table I About Here)

Implications of Child Abuse Reporting Statutes for Clinical Practice and Social Policy

Child abuse reporting laws, although enacted with the intent of protecting children from further injury by offering services to victims and their families, pose nonetheless certain conflicts for professionals who are faced with the need to act in these urgent clinical situations.

Conflicts for all professionals are felt especially keenly around the reporting process itself. On the one hand, an accepted tenent of child

abuse management tells professionals to be compassionate and to convey to parents their interest in helping to maintain the integrity of the family unit.

On the other hand, child abuse reporting laws force physicians and others to make judgements about families which they and the family may feel are onerous and heavily value-laden. Additionally, the perceived effect of reporting is to bring to bear a quasi-legal mechanism which, while in theory nonpunitive in orientation, may be the opposite in practice. In such States as Virginia and California, parents may be jailed as a result of the mandated case report.

One may thus be torn between one's legal responsibility to report and one's clinical judgement which may suggest that reporting itself may jeopardize the opportunity to develop a satisfactory treatment program for the family.

Often this conflict is expressed in reticence to inform families that they are being reported, reluctance and even frank refusal to report cases of abuse and neglect.

While there are no cut and dried decision rules which resolve this conflict definitively, two simple guidelines make it easier for the mandated professional to come to terms both with his/her legal responsibility and clinical judgement:

1) The family must be told that a report is being filed. Much of the apprehension which may surround the receipt of this information can be alleviated by explaining to the family what the reporting process is and is not. (e.g. it does not necessarily mean that their child will be taken away or that a court hearing will be held). The reporting process can best be presented to the family as a

referral of the family for services, and an explicit acknowledgement that they have a serious problem in protecting their child(ren) which others, including the reporting practitioner, can help to solve.

2. The mandated reporter can also explain to the family that the report represents an obligation on the part of the practitioner which he or she is bound by law to fulfil.

Often, rather than to produce a hostile or angry reaction, families will greet the news with relief. The reporting process may produce help which they have been seeking for a long time, and they may be relieved to hear that the suspicions others have had about them and their parenting are finally out in the open where they can be dealt with in a straightforward manner.

While such an approach to child abuse case reporting may palliate the anxiety of reporter and family, it does not remove the real, inherent labeling and stigmatizing aspects of the reporting process as it exists in most of the States today. Unfortunately, this is a problem that cannot be alleviated simply by a revision of reporting itself; it is rather an aspect of our society's perception of child abuse and the abusing parent. So long as child abuse is viewed as a form of radically deviant behavior, and as a symptom of pathology and sickness in others, i.e. not ourselves, the stigmatizing process will continue. All concerned to prevent and treat child abuse have, therefore, a responsibility to demythologize the problem: to recognize that the potential to act in ways which we identify as deviant is in all of us. Until attitudes and policies change toward troubled families, where children may bear physical signs of their distress, we shall have to work within the prevailing legal

framework and to assume to the extent possible that children and families are helped -- not harmed -- by it.

All State statutes abrogate privileged communication when it involves a case of known or suspected child abuse. In reporting to mandated State agencies, the reporter should identify the facts as they are known; hearsay and secondary source information can be labeled as such. At least forty-four States have provisions in their statutes for Central Registers and child abuse case reports; these registers may become repositories for information both founded and unfounded, depending on the expungement provisions of the individual statutes. Who has access to this information is left up to the individual States, and it is well to remember that information that is submitted in such reports may conceivably be used at some later date again to raise the issue of competency of a family or the risk to a child.

Where the articulated principle on which most prevailing statutes are built is that services should be made available to families in which child abuse has been reported as a problem, the reality in most States is that the actual funds available for the implementation of these statutes nowhere nearly approximates the existing demand for services. This problem has been seriously exacerbated recently by expanding reporting criteria and lists of professionals mandated to report cases of abuse and neglect.

(Table Two About Here)

Table II, which contains state-by-state reporting statistics collected by Gil in the late sixties contrasted with a recent survey conducted by Sussman and Cohen, demonstrate the massive upward trend in the number of cases reported. Protective services in Florida, for example, as the result of a new and enlightened child abuse reporting law and the implementation of a twenty-four hour state-wide child abuse hotline, have been inundated by reports and referrals. An unfortunate consequence has been that reports both founded and unfounded have reached the central state office and the personnel needed to investigate and evaluate these reports as well as ancillary support services - such as homemakers, child care, and adult psychiatric services - simply are not available in sufficient quantity.

Even in the presence of an efficient system for identifying families where child abuse has occurred, budgetary constraints may make it impossible for adequate services to be provided except in the most critical of cases. This makes it incumbent on the individual reporting a case not simply to view the report as a referral for service which will go forth with or without the professional's continued involvement in its management, but rather to assure that help will be given and that the family will not fall between the cracks of the service structure.

Summary of Child Abuse Case Management

There appears to be consensus in the literature on child abuse on seven axioms of management:

1. That once diagnosed, a child with inflicted injury or neglect is at great risk for reinjury or continued neglect.
2. That protection of the child must be a principle goal of initial intervention; but that protection of the child must go hand in hand with the development of a program to help the family.

through its crisis.

3. That traditional social casework in itself cannot protect a battered or neglected child in the environment in which he received his injuries. Medical follow-up, too, is necessary, and day-to-day contact with a child care center may help significantly to encourage his healthy development.
4. That in the event the child is reinjured and medical attention is sought anew, it is likely that his parents or caretakers will seek care at a different facility from where the diagnosis was originally established or suspected.
5. That the problems of public social service agencies in both urban and rural areas -- specifically in numbers of adequately trained personnel and in quality of administrative and supervisory functions -- militate against their effective operation in isolation from other care-providing agencies. Simply reporting a case to the public agency mandated to receive child abuse case reports may not be sufficient to protect an abused or neglected child or to help his family.
6. That early identification by professional personnel of the immediate agent of the injury or attempts to determine if neglect was "intentional", may be ill advised. However strategic the "facts" may be to the confirmation of diagnosis and treatment planning, clinical experience attaches the greater importance to the establishment of confidence and trust in the professionals who are going to intervene. This relationship may be jeopardized by overly aggressive attempts to elicit specific information on the circumstances of the injury. There is rarely any need to establish precisely who it was who injured or neglected a child and why. Lack

of evidence for parental "guilt", furthermore, is emphatically not a criterion for discharge of the patient.

7. That if there is evidence that the child is at major risk, hospitalization to allow time for assessment of his home setting is appropriate. Infants under a year of age with fractures, burns, or bruises of any kind are especially at risk for reinjury or for serious consequences of neglect. Prompt and effective intervention is vital to assure their survival.

Assessment of the Child and His Family

An adequate general medical history and physical examination are necessary at the time the child is brought to the physician. Photographs and a skeletal x-ray survey are performed when deemed appropriate. If a social worker is available she is called promptly at the time of the family's presentation, and her contact with the family is supported by the physician, who introduces her as someone interested and able to help them through this difficult period, and confers with her after her interview.

In the initial interviews and in subsequent contacts, no direct or indirect attempt to draw out a confession from the parent is made. Denial is a prominent ego defense in virtually all abusing parents, and the bizarre stories one often hears from them about how their children got their injuries ought not to be taken as intentional falsifications. These odd accounts often tell you how profoundly distressing it is to a parent to acknowledge having inflicted an injury or having failed to protect a child from someone else's having done so. In the face of such a threatening reality, they may deny it.

One does no service to parent and patient with assaults on the parent's personality structure. The third degree of its gentlemanly equivalent serves often to "harden" the defense or to promote more primitive defenses --- refusal to share meaningful personal data, angry outbursts directed at the interviewer, or at the hospital, or threats to take the child home immediately which limit both the process of information-gathering and the prospects for continuing helpful professional relationships, as well as possibly endangering the child. Rather, good interview technique allows parent and child to maintain the integrity of ego and family, such as it is in each case. Although spoken or suggested skepticism about the proferred explanation also operates deleteriously, it is appropriate to emphasize the child's need for care -- which may include his admission to a hospital -- and the need to assure that he is protected from harm. At this time one should demonstrate his concern and ability to help the parent as well.

In explaining his legal obligation to report the case, the physician's compassion and honesty will go far to allay the family's anxiety.

The opportunity to observe parent-child interaction and the child's physical and psychological milestones which might lead to insight into the familial causes of a child's injury may not be available to a physician in his office. Nurses in clinical and public health settings can and do, however, make such observations which are fundamental in casefinding and evaluation. Their competence contributes uniquely to diagnosis, and their perceptions should be shared appropriately with the physician and social worker seeing the family. A description of the child's development, perhaps augmented by a Denver Developmental Screening Test, and of his

interaction with his family, is usually recorded in the nurses' notes.

A home visit by a public health nurse or social worker is made with the objective of developing a reasoned perception of the child's home environment and of gathering data for the discussion of the child's disposition.

A psychiatric consultation is frequently obtained on cases of child neglect and abuse. It is often this consultant's perceptions which lead to understanding of what intervention by which personnel can be most effective. One must remember, however, that a psychiatrist can only rarely work magic, and that his consultation --- always desirable but often difficult to arrange --- should be a helpful adjunct to the planning process for the primary managers, social worker , physician, and nurse. Psychiatric consultation should not substitute for careful history-taking and diagnostic assessment by the personnel who will continue to follow the child and his family.

The essential elements of child abuse and neglect emergency management are summarized in Table 3.

(Talbe 3 About Here)

Translating these complex and sophisticated clinical practices into effective programs for large numbers of children and families is a challenge not to be taken lightly. In closing we should like to propose fourteen attributes of model systems for the prevention and control of child abuse and neglect. These general programmatic principles would apply at various levels of scale, from individual medical practice to hospital to community

service agency to state.

Attributes of Model Systems for the Control of Child Abuse and Neglect:

1. Child abuse seen as a symptom of family crisis, with professional services oriented to making families stronger.
2. Recognition of the community context in which child abuse occurs: attention to the values of the community, its indigenous techniques of problem solving, its traditions of child rearing, its resources and its leadership, in both the development of programs to help families, and in the approach to preventing child abuse on a larger social scale.
3. Services should be able to respond creatively to individual families' problems with services suited to their needs, to include:
    1. Social work counseling, liaison with other services and structures.
    2. Medical and psychiatric consultation and, where necessary, treatment.
    3. Advocacy.
    4. Child development services, including education, child care, and psychological intervention.
    5. Legal services.
    6. Temporary foster home care.
    7. Round-the-clock emergency services, such as homemaker services, to prevent family break-up and continued child abuse or neglect.
4. Protection of information about people; consistent and rigorous identification of the rights of children and their parents; and advocacy at all levels of intervention action to assure that fundamental civil liberties are not violated.

5. Regular evaluation of the effectiveness of intervention on several levels: for the individual case, both to assure continued physical protection and the promotion of health and psychological growth; and for the program in general, to assure the adherence to the highest principles of human service.
6. It would identify who is responsible to whom for what; minimize to the extent possible uninformed, reflexive, and precipitous action on the part of intervention personnel; maximize the career development possibilities for these personnel in the context of the program structure; integrate into the career development program a systematic method for recruiting and training professional personnel from minority groups; and allow for the acknowledgement and reward of successful work.
7. Services would be provided twenty-four hours a day.
8. There would be an adequate commitment of resources to assure that a successful program would be able to continue.
9. It would assure adequate legal representation for all parties in any court proceeding relating to child abuse; and active and high-level advocacy to assure judicial determinations consonant with the high standards of modern family law. Its goal would be to integrate families rather than to punish parents; to use the authority of the court, when necessary, to force family change; and, as a last resort when families utterly and completely fail, to allow children who are dependent on the state maximal opportunities for growth in homes they can identify as their own.
10. Administrative organization allowing both flexibility in staff development, supervision, and assignment and at the same time high-level access to the human services leadership, in order most

effectively to promote collaboration, constructive and mutual program planning, and, ultimately, the evolution of a human service system which would identify the family as the unit of practice, rather than as, at present, to fragment health, social and psychological problems into discrete program units.

11. It would incorporate child advocacy (as defined in the report of the Joint Commission on the Mental Health of Children) and child development education.

12. Systematic attention to the development of public policies which strengthen family life, based on what is already known about family strength and stress.

13. Citizen supervision of professional policies and practices through community-based Councils for Children.

14. The program should be population based: all people should be eligible for service. Neither a small-scale pilot program nor a major undertaking focussing only on the protection of the children whose cases happen to be reported, it should identify the dimensions of the problem, all possible avenues of individual and larger-scale intervention, and recruit and sustain the interest and participation of competent and varied providers of service. Emphatically, it should not be identified as a poor people's program, although it is certain that many children of the poor will be reported, partly but not exclusively because of the circumstances of poverty which may lead their families to fail. It should be a program to which private medical practitioners and voluntary family service agencies, as well as suburban school systems, would feel comfortable in reporting cases, because its services would be helpful and its orientation toward keeping families together and toward preventing child abuse.

Acknowledgements

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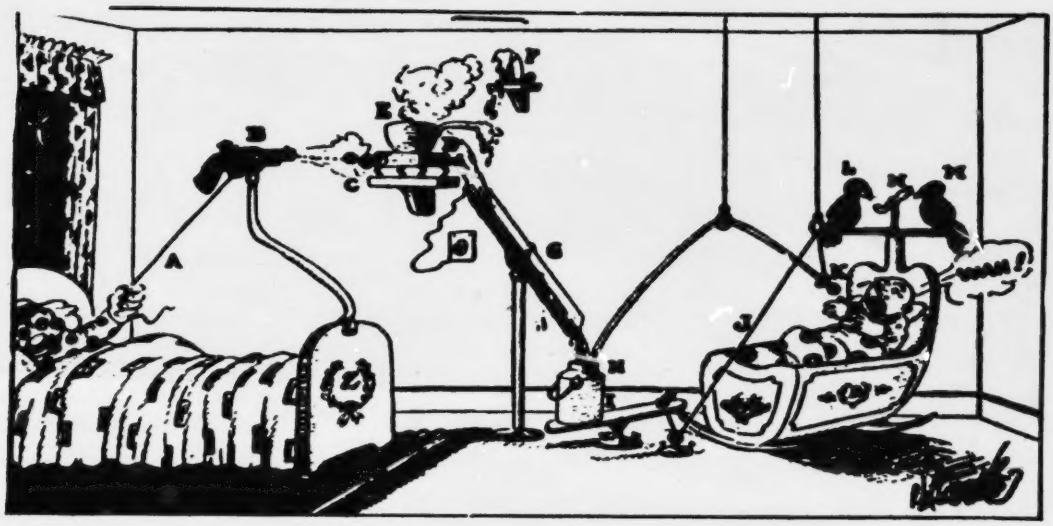

Figure 2

Rube Goldberg's portrayal of a father's successful control of his anger at his crying baby.

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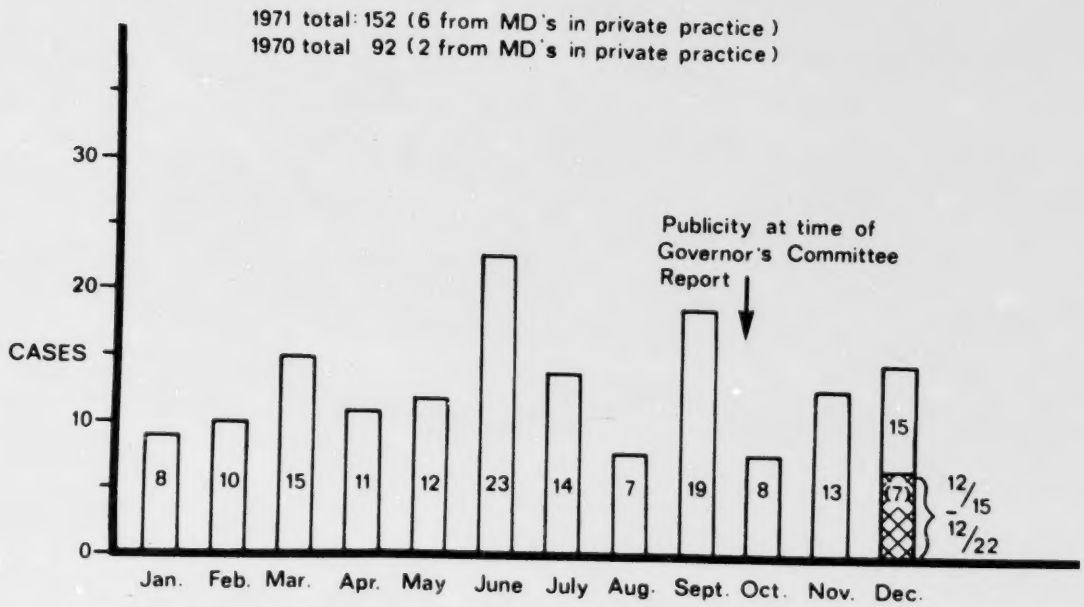

Figure 10

Case reports from physicians, Division of Child Guardianship, Boston metropolitan area, 1971.

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TABLE ONE

SUMMARY OF CHILD ABUSE REPORTING LAWS IN THE U.S.[1]

State	Law Last Amended	Purpose Clause	Age	Immunity	Penalty for Not Reporting	WHO REPORTS: Physician/Surg.	Resident/Intern	Dentists	Hospital/Inst.	Chiropractor	Pharmacists	Nurses	Teachers	Social Workers	Law Enforcement	Coroner/Med. Ex.	Psychologists	Optometrists	Podiatrists	Child Care Insts.	Clergy	Attorneys	Any Others	Misc.	TO WHOM: County Dept. Soc. Ser	State Dept. Soc. Ser	Juvenile Court	Other Agency	District Atty.	Police	WAIVER OF PRIVELEGE: Doctor/Patient	Husband/Wife	Other(except Att.)	All Privelenes	FORMAT OF REPORT: Oral & Written	Oral (only)	Written (only)	Not Specified	Central Register
Alabama	1969		16	X	X	X			X		X	X	X	X									X		X				X	X	X		X				X
Alaska	1971	X	16	X		X		X	X	X		X	X	X	X		X	X					X		X				X	X	X						X
Arizona	1972		18	X	X	X	X		X														X		X				X	X	X						X
Arkansas	1967	X	16	X	X	X	X	X	X	X	X	X				X							X	X	X				X	X	X						X
California	1973		12	X		X	X	X	X	X		X				X			X	X			X	X			X		X					X			X
Colorado	1972	X	18	X		X			X			X	X	X									X	X					X	X	X			X			X
Connecticut	1973	X	18	X	X	X	X	X	X			X	X	X	X	X	X				X		X	X	X				X		X			X			X
Delaware	1971	X	18	X	X	X	X	X				X		X		X	X						X	X	X				X	X	X	X			X		X
District of C.	1966	X	18	X		X			X														X		X				X	X	X			X			X
Florida	1971	X	17	X	X	X	X	X	X			X	X	X				X	X	X				X	X				X	X	X	X		X			X
Georgia	1973	X	18	X		X	X	X	X			X		X					X	X			X	X	X				X					X			X
Hawaii	1970		minor	X		X		X	X			X	X	X		X							X	X		X			X	X	X			X			X
Idaho	1973	X	18	X		X	X					X	X	X		X				X			X					X	X	X	X	X				X	X
Illinois	1973		child	X		X		X		X		X	X	X	X				X	X			X		X				X	X				X			X
Indiana	1971	X	child	X	X																		X	X					X	X	X					X	X
Iowa	1965	X	18	X		X	X	X	X	X		X						X	X				X	X			X	X	X	X				X			X
Kansas	1972	X	18	X	X	X	X	X	X			X	X	X	X		X						X	X		X			X	X				X			X
Kentucky	1972	X	18	X		X			X			X	X	X		X							X	X	X				X	X				X			X
Louisiana	1972	X	17	X	X	X	X		X			X	X	X									X	X				X	X	X	X			X			X
Maine	1965	X	16	X	X	X	X		X	X													X		X			X							X			X
Maryland	1973	X	18	X		X	X	X	X			X	X	X	X	X		X					X	X	Y			X	X	X				X			X
Massachusetts	1973	X	16	X		X	X	X				X	X	X	X	X	X						X	X		X			X		X		X		X			X
Michigan	1970		17	X	X	X			X			X		X	X								X	X	X	X		X	X	X					X			X
Minnesota	1965	X	minor	X	X	X			X		X	X											X						X	X	X			X				X
Mississippi	1973	X	18	X		X	X	X	X			X											X	X			X		X					X				X
Missouri	1969		17	X	X	X		X	X	X		X	X	X					X	X				X	X		X		X	X	X			X				X
Montana	1973	X	Minor	X		X						X	X	X	X							X	X	X	X	X				X							X	X
Nebraska	1973		minor	X	X	X			X			X		X									X	X					X	X	X			X				X
Nevada	1973	X	18	X	X	X	X	X	X	X		X	X	X				X		X	X	X		X	X		X		X	X	X		X	X				X
New Hampshire	1971	X	18	X	X	X			X														X	X		X			X	X				X				X
New Jersey	1973	X	18	X	X	X	X		X														X	X		X		X		X				X				X
New Mexico	1973	X	18	X	X	X	X					X	X	X									X	X	X					X						X			X

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TABLE ONE (Cont.)

State	Law Last Amended	Purpose Clause	Age	Immunity	Penalty for Not Reporting	WHO REPORTS: Physician/Surg.	Resident/Intern	Dentists	Hospital/Inst.	Chiropractor	Pharmacists	Nurses	Teachers	Social Workers	Law Enforcement	Coroner/Med. Ex.	Psychologists	Optometrists	Podiatrists	Child Care Inst.	Clergy	Attorneys	Any Others	Misc.	TO WHOM: County Dept. Soc. Ser.	State Dept. Soc. Ser.	Juvenile Court	Other Agency	District Attorney	Police	WAIVER OF PRIVELEGE: Doctor/Patient	Husband/Wife	Other(except Att.)	All Priveleges	FORMAT OF REPORT: Oral & Written	Oral (only)	Written (only)	Not Specified	Central Register
New York	1973	X	18	X	X	X	X	X	X	X		X		X	X	X		X	X	X			X	X	X	X				X				X			X	X
North Carolina	1973	X	16	X		X	X	X	X	X		X	X	X	X	X		X	X				X	X	X					X	X				X	X		X
North Dakota	1965		18	X		X	X			X		X											X		X			X		X	X				X	X	X
Ohio	1969		18	X		X	X	X	X			X	X	X					X				X		X				X	X	X					X		X
Oklahoma	1972		18	X	X	X	X	X				X										X	X		X					X				X				X
Oregon	1971	X	15	X		X	X	X				X	X	X	X								X		X				X	X	X			X				X
Pennsylvania	1970	X	18	X	X	X	X		X			X	X										X	X	X					X				X				X
Rhode Island	1971	X	18	X		X	X		X															X		X				X	X	X	X	X				X
South Carolina	1972		17	X	X																		X	X	X					X	X				X			X
South Dakota	1973		18	X	X	X	X	X	X	X				X	X		X	X	Y				Y	Y	X					X	X			X				X
Tennessee	1973	X	18	X	X				X														X		X	X				X	X	X			X			X
Texas	1973		child	X																			X		X					X	X	X		X				Y
Utah	1965	X	minor	X	X				X														X	X						X	X				X			
Vermont	1965	X	16	X	X	X	X		X	X													X	X						X				X				
Virginia	1973		16	X		X	X		X			X	X	X	X					X			X			X				X	X			X				X
Washington	1972	X	18	X	X	X		X	X	X	X	X	X	X	Y		X		Y		X		X							X	Y			X				X
West Virginia	1970	X	18	X	X	X	X		X			X	X	X									X		X				X	X				X				X
Wisconsin	1967		child	X	X	X		X	X			X		X									X		X					X				X				X
Wyoming	1971	X	18	X	X	X	X	X	X	X	X	X	Y	Y					X				X		X					X	X			X				X

1 Table abstracted from: "Child Abuse Legislation in the 1970's", Children's Division American Humane Association, 1974.

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TABLE TWO

COMPARISON OF 1968 REPORTING STATISTICS WITH 1972 EXPERIENCE

State	Gil's 1968 Survey[1]			1972 Sussman & Cohen[2]				
	Total	Abuse	Non-Abuse	Total Abuse and Neglect	Abuse	Neglect	Confirmed Abuse	Confirmed Neglect
Alabama	43	34	9	3826	87	3739	---	---[1]
Alaska	11	10	1	349	145	204	87	33
Arizona	2	2	0	---	---	---	---	---
Arkansas	20	17	3	4092	92	4000[2]	---	---
California	4016	1258	2758	39,564	5592	33,972	----	---
Colorado	78	67	11	373	373	---	---	---
Connecticut	78	73	5	----	--	---	---	---
Delaware	16	13	3	349	49	300	---	---
Florida	10	9	1	29,964	--	---	9,711[3]	
Georgia	62	55	7	320	320	NA[4]	---	NA[4]
Hawaii	42	35	7	1051	609	442	274	206
Idaho	2	2	0	---	--	---	---	---
Illinois	494	376	118	8011	1028	6983	---	---
Indiana	125	124	1	710	710	NA[4]	---	NA[4]
Iowa	186	132	54	---	---	---	---	---
Kansas	61	58	3	2331	888	1443	---	---
Kentucky	40	34	6	300	300	---	---	---

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State	Gil's 1968 Survey[1]			1972 Sussman & Cohen[2]				
	Total	Abuse	Non-Abuse	Total Abuse and Neglect	Abuse	Neglect	Confirmed Abuse	Confirmed Neglect
Louisana	14	13	1	----	---	----	----	----
Maine	5	4	1	----	---	----	----	----
Maryland	504	324	180	----	---	----	----	----
Massachusetts	156	114	42	3512	212	3300	201[2]	----
Michigan	721	539	182	16,204	1748	14,456	----	----
Minnesota	107	95	12	262	262	NA[4]	---	----
Mississippi	23	22	1	29	29	----	---	----
Missouri	72	54	18	935	935	NA[4]	---	NA[4]
Montana	11	8	3	----	---	----	---	----
Nebraska	16	16	0	----	---	----	---	----
Nevada	39	31	8	----	---	----	---	----
New Hampshire	23	20	3	----	---	----	---	----
New Jersey	50	37	13	3214	---	----	----	----
New Mexico	13	13	0	----	---	----	---	----
New York	989	574	415	3319	3319	----	---	----
North Carolina	155	102	53	10,064	1602	8462	---	----
North Dakota	2	2	0	9	9	----	---	----
Ohio	146	128	18	1119	---	----	---	----

Table Two
Page Three

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State	Gil's 1968 Survey[1]			1972 Sussman & Cohen[2]				
	Total	Abuse	Non-Abuse	Total Abuse and Neglect	Abuse	Neglect	Confirmed Abuse	Confirmed Neglect
Oklahoma	12	12	0	400	---	----	---	----
Oregon	30	30	0	347	---	----	---	----
Pennsylvania	555	385	170	1080	1080	----	532	----
Rhode Island	0	0	0	2060	---	----	1502[3]	----
South Carolina	41	38	3	27	27	----	---	----
South Dakota	0	0	0	----	---	----	---	----
Tennesee	116	72	44	372	372	----	98	----
Texas	1282	1282	0	1027	---	----	338	----
Utah	27	17	10	----	---	----	---	----
Vermont	7	6	1	12	12	----	---	----
Virginia	48	35	13	92	92	----	---	----
Washington	122	81	41	5500	1200	4300	---	----
W. Virginia	16	15	1	41	41	----	---	----
Wisconsin	296	213	83	632	632	NA[4]	---	NA[4]
Wyoming	4	4	0	178	59	119	---	----

(1) Not available
(2) Estimated
(3) Total Abuse and Neglect
(4) Not applicable

1 Gil, D.G., Violence Against Children, Cambridge, Harvard University Press, 1970, pp.93-94.

2 Cohen, S., and Sussman, A., "The Incidence of Child Abuse in the United States", Unpublished paper, Juvenile Justice Standards Project, Institute for Judicial Administration, New York University School of Law, 1974, pp. 7-10.

TABLE THREE

CAPSULE SUMMARY OF THE EMERGENCY MANAGEMENT OF CHILD ABUSE AND NEGLECT

1. Diagnosis - Is this child at risk? If his presenting complaint arouses suspicion, act on it forthrightly and compassionately. Protect the child and help his family.
2. Intervention - Is it safe to send the child home?
   A. Admission to the hospital considered in suspected cases and often when the diagnosis of abuse or neglect is established.
   B. Social worker called.
3. Assessment
   A. General medical history and physical examination. "Who did it?" is not the issue. Avoid the third degree.
   B. Initial interview and assessment of the family by a social worker; development of understanding of family's strengths and resources.
   C. Nursing evaluation of child's development, parent-child reatlionship, and family's participation in community health structures.
   D. Honest explanation of the legal responsibility to report the case to the Welfare Department by the physician.
   E. Report to the public agency mandated by law to receive reports of cases of child abuse and neglect.
   F. Photograph and skeletal survey if indicated.
   G. Appropriate consultations, especially psychiatry, as indicated.
   H. Communication among physician, social worker, and nurse to decide program of care.

Table Three
(Continued)

4. Intervention Program

   A. Initiation of rehabilitative efforts for both child and family.

   B. Mobilization of hospital and community resources which may be available for the family, e.g. child care, foster placement, community family service and health agencies.

5. Follow-up

   A. Primary medical care arranged.

   B. Social service follow-up - community service or public agency, as indicated.

   C. Nursing follow-up as indicated.

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